NHS
Norfolk and Suffolk
NHS Foundation Trust

Trust Management
1st Floor Admin
Hellesdon Hospital
Drayton High Road
Hellesdon
Norwich
NR6 5BE

Our Ref. ML/AL
Your Ref.

- 7 JAN 2019

Private and Confidential
Mr Parsley
Suffolk Senior Coroner
The Suffolk Coroner's Service
Beacon House
Whitehouse Road
Ipswich
Suffolk
IP1 5PB

3 January 2019

Dear Mr Parsley

Re: Mr Matthew Arkle

I write in response to your report dated 13 November 2018. Under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013 you requested the Trust consider issues of service delivery following the conclusion of the inquest into the death of Mr Matthew Arkle.

You raise a number of areas of concern which I respond to in order:

Verbal and written communication

The inquest heard that Matthew's family would not be able to visit him at the Wedgwood Unit on 4 April 2017. Three family members had spoken with staff asking that any request for unescorted leave be declined for that day. The inquest heard that the staff on duty on 4 April 2017 were unaware of such a request and there was no written communication to this effect.

Communication is a vital component in maintaining safe and effective care. The Trust uses systems such as an electronic patient record to document patient care, as well as frameworks to handover information (Situation, Background, Assessment, Recommendation (SBAR)). However, this tragic event highlights the human aspect of receiving information and ensuring it is fed into these communication structures.

There is no current single evidence based tool which can be implemented to eliminate this potential. However, shared understanding amongst staff of the processes of receiving information is critical to reduce variance. To this end we have issued an internal alert to all our inpatient wards directing reflection on the points where information is received from external sources e.g. families and carers and whether there is a shared process or understanding of how to ensure that information is captured. Where there may not be a shared understanding the ward will work to address this. Feedback from this alert will be shared across the wards to promote wider learning.

General high level of activity and stress on Northgate ward on 4 April 2017

The inquest heard that although staffing met the required levels, there were a number of service users requiring additional supervision and a high number of alarms being activated throughout the shift.

The activity on a ward can vary from day to day having an impact on the experience for service users, visitors and staff. It is important that services can adapt to changing needs. The Trust has been in process of using a validated tool (known as the Hurst tool) to assess the activity of wards. Having completed the required observations the Trust is now receiving the externally validated reports. These will be used to guide future practice. Our intention is that by using a validated tool it will support evidence based decisions supporting safety and quality of care.

Delay in noticing, reacting and reporting Matthew as missing.

The inquest heard there was a lack of clarity of the time that Matthew went on unescorted leave, with an initial recording of it being at 19.00. CCTV footage enabled a closer estimation of the time being no later than 17.30. Subsequently, Matthew's leave should have ended at 18.30 but it was not until 21.06 that he was reported as a missing person to the police.

It is vitally important the Trust employs suitable processes to ensure accurate recording of times when service users are present on or away from the ward. Of equal importance is a shared understanding of the time when a person goes on leave and that there is prompt alarm and action should they not return at the agreed time.

The Trust has issued an internal alert highlighting the need for clear processes to support this, and learning from areas with strong actions will be shared and adopted amongst the Trust.

Trust policy *Missing Persons and Failure to return from Leave* supports staff actions when a person does not return from leave. This guides the process of actions and completion of information with a specific form that is provided to the Police. This policy was created with Norfolk and Suffolk Police and published in May 2017.

Timing of Matthew's release on leave being in the late afternoon.

The inquest heard that it was well documented that Matthew's symptoms of auditory hallucinations became strongest in the evening, often associated with a lowering in his mood.

The Trust's Root Cause Analysis report examined the timing of Matthew's leave and whether the practitioner in charge was aware of his symptoms and how hallucinations could become stronger in the evening, influencing his mood. The report identified the practitioner was aware of Matthew's presentation and the balance of what distraction could offer. The report identified the assessment was satisfactory with Matthew presenting positively in language and manner.

Understanding and research of suicide does not yet provide us with a structure by which to predict people taking their lives, with tools giving broad indicators of higher risk. This means assessment relies partly on judgement. Regrettably, we will not know the mental torment Matthew experienced preventing him from speaking about any thoughts of suicide with the staff at that time. Equally, we will not know whether these thoughts became more dominant or surfaced once he went on leave.

If I can be of any further assistance please do not hesitate to contact me.

Yours sincerely

Antek Lejk
Chief Executive